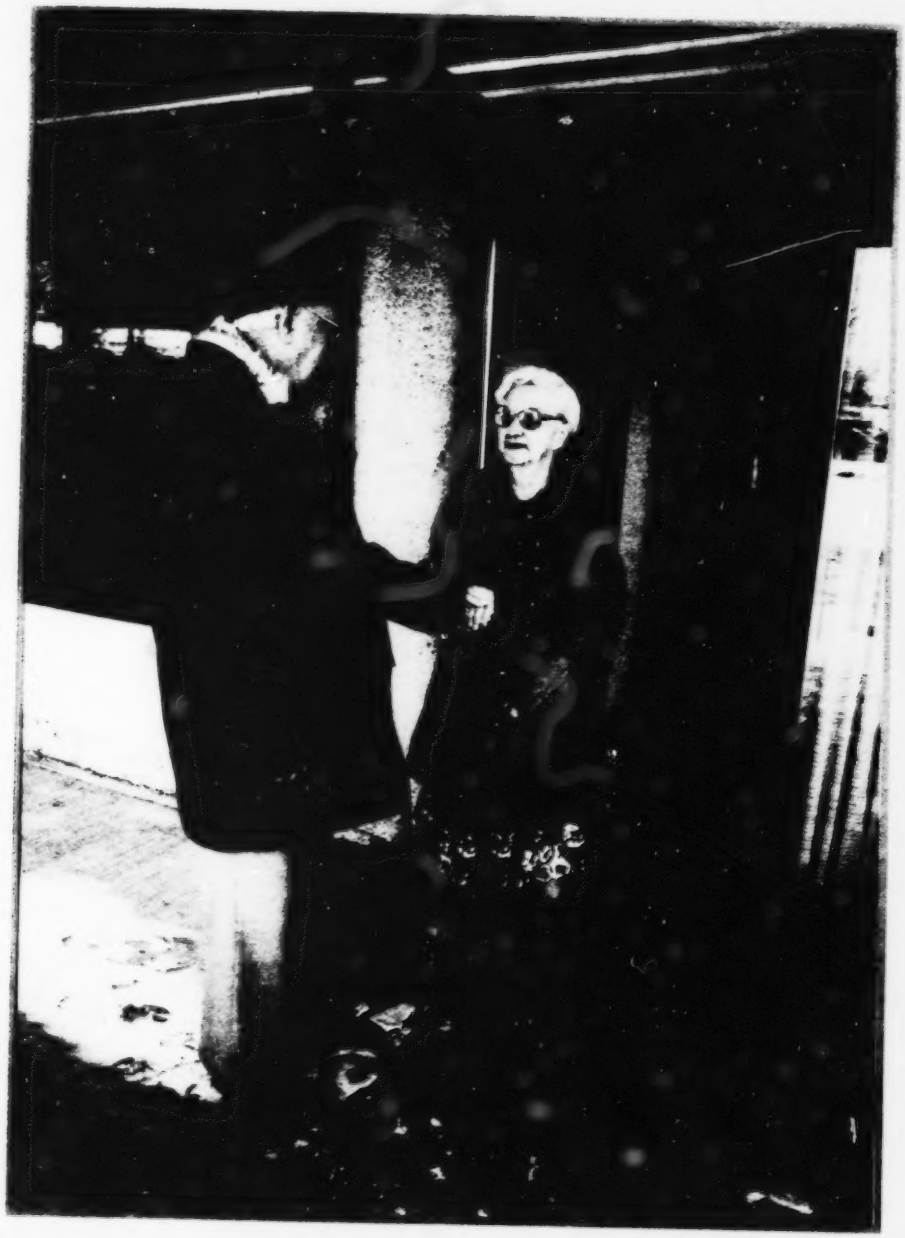
A NEW BEGINNING

A REVIEW OF THE NEEDS OF SENIORS IN THE PEACE RIVER HEALTH UNIT



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VOLUME I
Executive Summary

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The Regional Interdisciplinary
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The Senior Citizens Bureau
The Manning Hospital Board
The Northern Alberta Development Council

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INTRODUCTION

Increasing concern about the 'aging' phenomenon of the Peace River area's populace was the push behind this assessment study. Various agencies and organizations had noted a wide range of socio-economic requirements--ranging from the need for senior citizen housing and long-term care to the problems seniors face in maintaining social and family contacts to the necessity to plan for old-age.

A co-ordinated interdisciplinary approach to find solutions was clearly indicated. Therefore, a committee was formed in April, 1984, to plan a research program around a needs assessment of the area. The Steering Committee for Geriatric Needs was familiarly known as the 'Geriatric Committee'.

It was soon obvious that more information must come not only from the agencies that deliver services but also from senior citizens. Consequently, a 6-phase research program was established.

This assessment study deals with the first four of these phases, analyzes the data gleaned from seniors and agencies, and discusses the findings.

OBJECTIVES AND PURPOSE

The Geriatric Committee established eight general research objectives:

- to describe the senior citizen populace
- to describe their use of health care services
- to report seniors' opinions regarding current services
- to identify services required to keep seniors independent for as long as possible
- to describe seniors' housing conditions and to identify their future requirements
- to identify seniors' information needs
- to describe an effective means of transmitting information to seniors
- to describe and promote the development of a 'services co-ordination model--a what-to-do structure--which includes participation among planners and users, that is, seniors.*

The objectives arose from the Committee's stated purpose of initiating a co-ordinated approach to planning and delivering services in response to the perception of seniors themselves and of the people who provide such services. Better ways to inform seniors of, and to encourage them to use available resources were also sought.

Phases of Research

To achieve all these things, the Committee established a six-phase research program:

Phase I — Seniors Registry
Phase II — The Research Design, Training and Agency Survey
Phase III — Survey of Seniors
Phase IV — Analysis and Report
Phase V — Planning, Promotion and Implementation
Phase VI — Evaluation**

* This objective is not addressed in the report. It is viewed as part of a long-term implementation component. Phase V will deal with this through workshops.

** Parts V and VI are not addressed in the report since they are viewed as implementation phases.

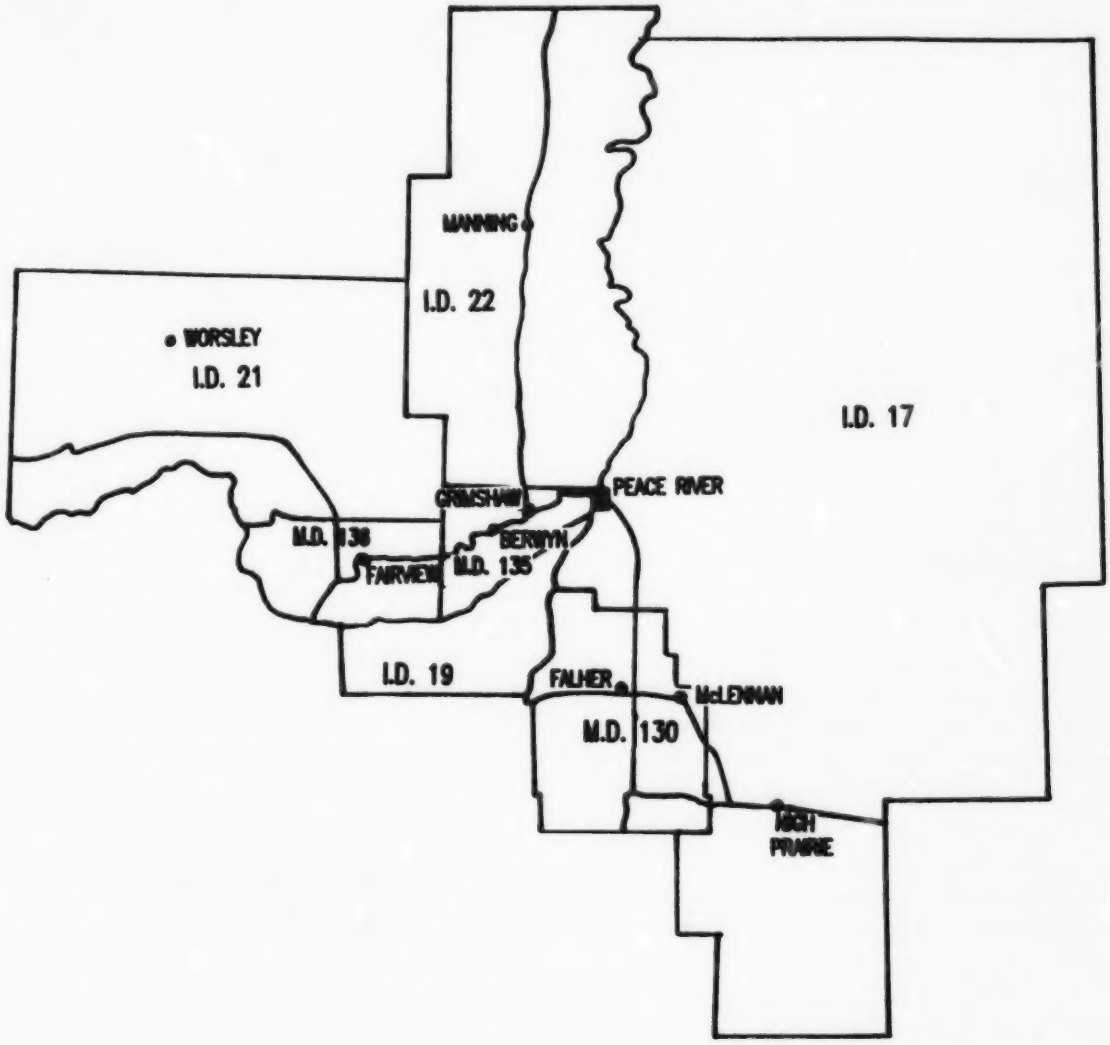
Study Area and Funding

The Peace River Health Unit District which serves about 40,000 people, made up the study area. The area is largely rural and small town in nature although there are six larger towns in the 44 255.75km^2 (27,500 mi.^{2}) expanse.

The Committee received funding from the Peace River Health Unit, the Northern Alberta Development Council, the Alberta Senior Citizens Bureau and the Manning Hospital Board. Total funding amounted to $33,500.

Although the Peace River Health Unit was named sponsor, the Committee retained autonomy and made all decisions.

PEACE RIVER HEALTH UNIT NO. 21



EXPLANATION OF STUDY PHASES

Phase I -- THE SENIORS REGISTRY

From September to December, 1985, a registry of 3,000 people over age-60 was compiled. All seniors' organizations, homes, lodges, auxiliary hospitals, home care nurses, community workers and family and community social services departments contributed lists. Many names came by word-of-mouth.

The Registry, although invaluable, is difficult to maintain because of constantly changing data: deaths, migrations and people newly arrived in the age group.

Phase II--RESEARCH DESIGN, TRAINING AND AGENCY SUMMARY

All pertinent printed information was reviewed. Every area agency with services and programs for seniors was identified and its programs tallied. Only then did Committee members begin to design a questionnaire to use in interviewing agencies—20 key agencies were interviewed. The same data were also helpful for the seniors questionnaire.

Phase III -- SURVEY OF SENIORS

Following the agency review, a questionnaire was carefully devised after much brainstorming, pretesting and revision. Its purpose was always seen as a means of receiving and recording what seniors themselves believe to be their service, their dependency and their independency needs.

With the help of consulting researchers, a survey was designed:

- to collect data via random sampling in the Peace River Health Unit boundaries
- to observe proportional representation both in eight sub-areas of the Unit and in four separate types of housing
- to collect data through personal interviews with people over the age of 65
- to interview 10% of the senior population in the study area–350 people in more densely settled territory and another 50-plus in remote communities

In response to a call for volunteers, 53 people took day-long training and subsequently did the interviews. The Committee was impressed by the high calibre of volunteers and by the quality of their work.

PHASE IV–ANALYSIS AND REPORT

A vast amount of data was collected but organization and analysis were simplified through the use of a computer.

LITERATURE REVIEW

This review was conducted so that material related to seniors' programs in the North and other references to this age group might be identified. Publications were divided into three major categories:

1. general perspectives on aging
2. Alberta literature dealing with the topic
3. needs of Alberta's northern seniors

1. General Perspectives on Aging

There are currently five accepted aging theories:

a) **Disengagement Theory**--suggests that aging is a process where the older person and society mutually withdraw from one another in preparation for death.

b) **Activity Theory**--allegedly denies that old age is a stage of life with different qualities from middle-age and indicates that people try to prolong middle age life patterns despite aging. (Those who develop programs for the elderly usually are influenced by this theory.)

c) **Continuity Theory**--views aging as a process involving changing psychological, biological and social aspects at the same time as effort is made to maintain familiar habits and patterns.

d) **Accommodation Theory**--suggests that adjustment to retirement begins as soon as retirement is considered and slackens as new behavior patterns and non-work roles are adopted.

Unfortunately, no single theory adequately explains what occurs during aging. It is important, therefore, to be aware of all the theories when developing and putting programs into place.

Research into aging has also focused on services delivery. One finding, not always considered, is that seniors should be consulted before programs involving them are ever designed. A U.S./Japan conference held in 1984 recognized four basic criteria for developing policies for the aged:

- Rely on the community's social structure, values and culture as resources.
- Ensure programs are in harmony with the society's traditional institutions.
- Ensure programs are sensitive to the many different needs of the age groups and that they are in accord with each other.
- Make humanistic need, rather than economic, the guiding force.

This conference also noted that the policy goal should be the dignity and well-being of the person.

Physiological Aspects of Aging
Most gerontologists (people who study aging and the aged) no longer

view aging as a time of senility but, rather, see it as a period of changing physical ability with several distinct stages. People have different needs at each of these different stages.

The elderly are defined as those over 65-years-of-age. Within that category are three distinct groups: young-old (65-74); middle old (75-84); old-old (85+).

Evidence shows that the body's ability to function at capacity begins to decline early--probably about age-30. However, there usually are no severe health problems until later in life.

In Alberta, it is estimated that 15-20% of seniors need services because of either physical or mental frailty. Most elderly people do have some form of chronic illness, that is, some long-term problem, such as arthritis. Acute problems (those that are short-term) are more serious for seniors than chronic problems because the body and its organs have all degenerated through the years.

In the later stages of aging, three significant changes take place:

- Critical organs and body systems deteriorate with an accompanying vulnerability to disease.
- Muscular wasting and associated nervous system changes result in circulatory problems in the brain.
- Such senses as sight and hearing lose their acuteness.

All these things affect the type, variety and frequency of health care delivery.

2. Alberta Literature and Needs of Alberta's Northern Seniors

Alberta data disclose much about both the province's aging population and its needs. Also, programs and policy development are well-documented. The following points summarize the data contained in that Alberta literature studied:

- In 1981, Alberta had 163,390 persons 65-years-of-age or more; this constituted 7.3% of the population.
- Projections show an increase of 136,510 elderly persons between 1981 and 2006.
- In 1981, the average life expectancy at birth in Alberta was 71.4 years for males and 78.6 for females.
- Albertans are living longer. In 1981, 38% of the elderly were 75-years-old and 9% were 85-years-old. By the year 2006, people over 75 may be 43% of the senior popuation while the number who are 85-and-older may reach 10%.
- In 1981, there were 14,920 more older women than men. Women made up 55% of the senior population.
- Women use more health services than men.
- Nearly two-thirds of seniors lived in families in 1981.
- Between 1971 and 1976, extended family living decreased by 2%. (1981 figures are not available.)
- Families represent the senior's most important means of staying out of institutions.
- One-third of women 65+ live

alone and experience severe loneliness.

- The proportion of seniors, especially women, living alone is increasing.
- Between 1966 and 1981, there was a slight trend toward increased urbanization of seniors.
- The highest concentrations of seniors were in smaller urban and rural non-farm areas.
- Rural communities often lack services and good transportation which has severe implications for the aging.
- The elderly fear violence.
- Life satisfaction is often influenced by income.
- Each of the three different groups of elderly has different needs and interests. These differences affect structure and delivery of programs.
- Since 1980, in response to government policy changes, attempts have been made to co-ordinate, evaluate and develop alternate programs for seniors.
- Major problems exist re long-term care for the elderly:
  - negative attitudes toward the aged and aging, even from physicians
  - inadequate knowledge of research into aging
  - lack of alternate care methods with resulting over-use and/or misuse of institutions
  - inadequate assessment and classification of physical, mental and emotional status
  - inappropriate placement
  - lack of co-ordination among services
  - no common philosophy regarding provision of long-term care services.
- Crisis situations develop quickly in the elderly.
- Services to deal with crises must be in the right place at the right time. Co-ordination of services could help in this regard.
- There is a move in Canada and the U.S.A. toward deinstitutionalization of the aged, with home care seen as one of the favored alternatives.
- Home care programs tend to foster greater independence and to maintain dignity and wellbeing.
- These programs also provide support for families.
- Home care programs have been expanded in Alberta with Health Units now revising programming.
- In Canada as a whole, 9.6% of those over 65 are in institutions. This compares with 5% in the U.K.
- It is theorized that 7,500 fewer Albertans would be institutionalized if the U.K. system were adopted here.
- Some seniors need protective care; a test project will soon be in place in Alberta to ensure that appropriate placement and services occur.
- The elderly are not always aware of available health services and facilities.
- There is an over-reliance on physicians.
- Many physicians and community health nurses need improved geriatric training.
- The 'at-risk' elderly in each community need to be identified and assisted when necessary.
- Seniors need to be involved in community life.
- Seniors need to be involved in decision-making that affects them–programs, etc.
- Seniors can help one another.
- Many seniors have an alcohol

problem.

- Northern seniors face all the same problems as those in other parts of the province but often these are more severe because of the distance and isolation. As well, most northerners face relocation to a strange community when they are institutionalized.
- Home care programs in the North are extremely expensive because of dispersed population and the need for extensive travel.
- There is a shortage of trained medical personnel in the North.
- There are no long term care institutions for seniors north of Peace River.
- The upper third of the Northern Alberta Development Council area is not serviced by nursing homes or other adequate auxiliary facilities.
- Special medical treatment requires leaving the North.
- What works in urban situations often does not work in the North.
- Northern Alberta has many challenges to meet in order to develop and maintain a quality life for seniors. This can be possible with the involvement of our biggest resource — our seniors.

ANALYSIS OF AGENCY INTERVIEWS AND QUESTIONNAIRE

Key agency personnel (those in authority) were interviewed as soon as a preliminary list of agencies existed. Twenty interviews took place in September, 1985.

Specifically, agencies were queried about program delivery problems, future programming plans and information needs. It was found that even though agency personnel usually have clear ideas about what ought to be in place and, in some cases, are working toward achieving these, many agencies do not have the autonomy to originate new programs since they are directed from head offices elsewhere.

The following are areas where new programs might be valuable:

- physiotherapy departments in hospitals
- opthalmology services
- extended care beds in more hospitals
- better liaison between mental health services and area hospitals
- adequate number of self-contained units
- adequate number of lodges
- transportation services
- extended handyman services
- expanded recreational programming
- programs involving such health-related issues as foot care and reflexology
- religious support groups
- continued visiting services from church groups

- regional conference for seniors
- expanded adult education programs

As well, many gaps in programming were indentified:

- Seniors tend to be spectators rather than participants.
- Many seniors are lonely and/or depressed.
- Often personnel are unaware of the programs and activities of their own agencies.
- Much information fails to reach native people.
- There is a communications gap among seniors themselves.
- The role of lodges must be clarified.
- Differentiation between handy-

man necessity services and handyman luxury services must be identified and maintained.
- Although transportation services for the elderly are clearly necessary and important, no clearcut plans or priorities exist.
- No specialized mental health services for the elderly exist in the entire Peace region.
- Serious placement problems exist.
- Problems arise as a result of geographic vastness and sparse population.
- Preventive care is inadequate.
- Seniors 'at-risk' should receive special monitoring.

Characteristics which place seniors in the 'at-risk' category have been identified as follows:

- 75-years-of-age or older
- socially isolated, living alone or enduring family dysfunction
- locomotor problems
- without the information or abilities to access help
- recent bereavement (within two years)
- potential malnutrition
- recent discharge from hospital
- recently rehoused
- incontinence
- mental confusion
- special medical problems

- Agencies noted that services are most often provided to the 'at-risk' group after the fact since almost no monitoring of this group takes place.
- Recreational programming suffers from lack of variety.

Overlapping of programs is a problem. Sometimes, several agencies serve the same client or deliver similar programs.

Seniors see themselves as old people who are behind the times and on the outside looking in. They promote this image, to a large extent, by failing to stand up for themselves, with the end result that their behavior is viewed as fearful and suspicious. This is especially noticeable in their dealings with government agencies and programs.

A surprising finding of the survey was that a full 35% of the agency sample was not completely aware of major health programs available in the region. Ten per cent of these had no knowledge at all of the programs offered.

Agency interviewees were able to provide a comprehensive list of needs. The following concepts were noted in this regard:

1. Quality of life

Seniors, like everyone else, need and deserve quality of life. Several things could be done to help them achieve this.

- When able, they must be allowed to look after themselves.
- Seniors must have input both to what happens to them and to what happens in the institutions where they live.
- Although seniors usually need help, they are often too proud, too stubborn or too fearful to ask for it.
- Seniors need and deserve respect.

- It is important for seniors to deal with the present rather than with the past. Often agencies do not allow or encourage this.
- Seniors become depressed when their families fail to visit or when they visit rarely.
- Seniors need to be and feel useful.
- Seniors need to become more involved both with their families and their communities.
- They need assurance that their dignity will be maintained.
- They need new approaches and techniques as they near the end of their lives.

2. Medical Needs

Some deficiencies in medical delivery were noted.

- Seniors need better access to medical assistance.
- They need foot care programs.
- They need eye care and hearing programs. Many do not know how to care for their hearing aids, how to get a proper fit or prescription, or how to use them effectively. Eye and ear care must start far earlier than it now does.
- An emergency phone number for seniors is necessary. This is especially vital for those who live alone.

3. Accommodation Needs

Several specific needs to do with housing were identified.

- Seniors hate to leave their own communities.
- They need safe places to live.
- Institutions providing multi-levels of services are best, and these are needed at this time.
- Lodges must create healthy atmospheres for residents.

4. Transportation

Lack of transportation robs seniors of independence as well as preventing them from taking part in many things that go on in the community.

- The mini-bus in Peace River does not meet all needs because of limited hours of operation.

5. Financial Needs

It is well-known that seniors do not always have enough money. This lack affects them in several ways:

- They need meals at reasonable cost.
- They are often forced into smaller and cheaper accommodation which precludes entertaining.
- They may not have the money to visit their family.
- Their independence may be curtailed.
- They may be unable to participate in recreational activities.

6. Outreach Programming Needs

- A volunteer services co-ordinator is required.
- Visitors 'friendly' program needs expanding.
- Handyman service needs expanding and overseeing.
- Seniors need an 'adopt-a-grandparent' program.
- Seniors need contact with young people.
- Seniors must all have access to and information about programs.
- Some seniors need reintegration to normal community life.
- Seniors are lonely much of the time.
- "Meals on Wheels" does not reach enough of the senior population.
- Some way to meet nutritional needs of seniors should be put into place.
- Home-care programming does not yet reach seniors soon enough.

7. General Programming Needs

- Female seniors often do not have experience in decision-making and financial matters.
- Motivation is a big problem.
- Different languages must be acknowledged.
- Information geared to seniors should be in larger print.
- Seniors need support (with necessary care) for as long as possible in their own home environments.
- They need to be visited often.
- They need help with facility management.
- They need the opportunity to share ideas.

8. Information Needs

- A registry of seniors would help.
- Greater co-ordination, discussion and information sharing among agencies would be helpful.
- A list of agencies and organizations involved in seniors' programming would be of help.

ANALYSIS OF THE SENIORS QUESTIONNAIRE

More than 400 seniors, many of them original pioneers of the Peace River area, were interviewed. Some had received their educations in other countries or in other areas of Canada and most had not gone beyond grade seven or eight. Many had far less education than that, with the average completed grade in the remote area, (isolated native communities), being grade two.

Also, some lack of understanding of the written word emerged. Not only is there a generally high illiteracy rate, but many had mother tongues that were other than English. All these things affect the way seniors wish to spend their twilight years. As well, they affect the information delivery system.

Many who are French-speaking, for example, stipulated that they would only leave their present communities if they could move where French is spoken. Native seniors do not consider moving from their home communities at all. If health reasons force seniors from their homes, most, regardless of where they live, would choose to stay as close as possible to their present homes.

Some declared they would never move into a lodge or nursing home. Others see such a move as a last resort and many indicated they are fearful of losing privacy and independence.

Most seniors now live in houses and about ¾ of these are self-owned. Only a few are accommodated in room-and-board situations and some live in seniors' apartments. Very few had plans to move, citing satisfaction with present accommodation and need for independence as reasons. Those who did plan relocation want to be closer to family, and especially to grandchildren. A few are seeking a better climate. Only in remote communities did lack of amenities figure in plans or wishes to relocate. In these remote communities a distinct lack of services was noted: running water, sewage, central heating, electricity, etc.

About ¾ of seniors now live in towns and villages with the remainder in rural areas. Almost half live alone. In remote communities, more seniors live with families than in other regions.

Residents of the remote region have seldom made plans to relocate even if health fails, and, in other areas, only 17.7% have contingency plans in case of loss of health. About half of seniors claim good health, and although this varies from community to community, fewer in the remote

region suffer poor health than in other areas.

Some foresaw that their families would care for them, if need be, but many thought that would be unfair. Remote residents, who indicated they would not relocate even for health reasons, count on their families to look after them.

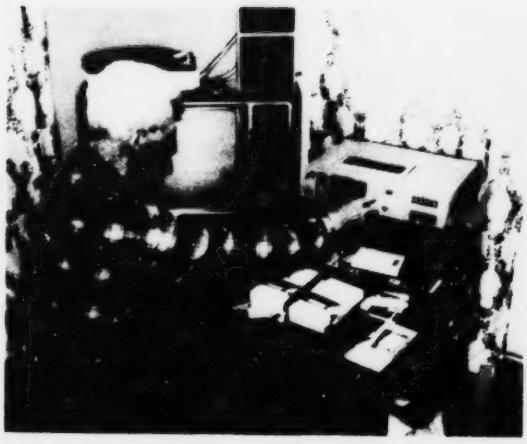
Less than half of seniors interviewed in settled areas had failed to prepare for old age while in the remote region a mere 10% had planned for this time of life. On the other hand, most expected life at this age to be much the way it actually is.

Although seniors are seen as poor, from 75.9% to 96.25% in developed areas feel they have adequate incomes while only 34.6% in remote areas believe the same.

USE OF SERVICES

Several health and health-related services are offered in the Peace River Health Unit area. These include:

- community Health Nurses
  - -- Blood Pressure Clinics
  - -- Immunization Service
  - -- Home Visits
- Hospitals
- Eye Specialists
- Dental Services
- Alberta Aids to Daily Living/Extended Health Benefits (AADL/EHB) supplies and equipment
- Home Care
- Health Unit Hearing Service
- Meals on Wheels
- Mental Health Services
- Speech Therapy



- Drop-in Centres

Some services, like ambulances, are not available in remote areas, but Home Care received its highest usage there. Dental services and meals on wheels received highest usage where readily available. The remote areas are not, at present, well-served by these services.

Remote residents in fact, used health care services (with the exception of hospitals) less often than other services. The most used were Community Health Blood Pressure Clinics, hospitals and eye specialists.

A surprisingly low number take advantage of drop-in centres--17% in Peace River and this was the highest usage recorded in the region. Most remote communities do not have special senior centres but even there, only 20% use the community centres that do exist. Reasons vary for this, but many expressed the opinion that programs lack interest and variety. Transportation difficulties were also citied as a reason for non-use. However, those who do make use of the Centres are satisfied with them.

INDEPENDENCE

Throughout the survey, seniors emphasized their desire to maintain independence. This was cited as reason for not wanting to leave their communities, for wanting better transportation, for avoiding institutionalization. Seniors generally are appreciative of programs geared to helping them maintain independence although some proudly proclaim that they take care of things themselves, get their children to help, and have always looked after themselves.

Even so, most do wish help with such things as transportation, shopping, government forms, legal problems, home chores, such health concerns as medication, toenails and home care. Most are willing to pay something for these services although some believe government is obligated to bear the cost.

Home Care received many bouquets but adult day care was less well-known although interest was expressed in learning more about it. Surveyors were not surprised at this finding since adult day care is relatively new.

Lodges and home-care are well-known to most. As well, nearly all know how to access spiritual guidance.

Seniors seem to ask for information on arthritis and blood pressure most often, although information on personal growth and finances were viewed as useful in preparing for life as a senior. On the other hand, information on recreational and cultural matters, on education, medical, accommodation and

spiritual concerns were not viewed as helpful in this respect.

Although ¾ of seniors would like to register for further information, Remote residents were exceptions to this.

PARTICIPATION

Many seniors do not participate in activities and programs available to them. Reasons for this vary. Some are not in good enough health; some lack transportation; some no longer feel like getting involved. Quite a few declared themselves already so involved and busy that they have no time for programmed activities.

However, the pool of people that make up the senior population is largely untapped as far as

volunteers are concerned and many expressed an interest in doing volunteer work. At the same time, few were keen on part-time jobs. Several would like to be involved in seniors' program planning.

Most preferred activity was visiting, a preference that is directly linked to their antipathy to sharing a room in a nursing home or lodge and is also related to their wish for independence.

CONCLUSIONS

Analysis of the responses led the committee to several conclusions:

- Women currently make up the majority of the 65+ population. It is likely they will always do so and this could affect programming. As well, since about half of respondents remain married and in their own homes, programming to assist in caring for spouses may well be needed; education regarding available options and special accommodation for couples in facilities may also be required.
- Support groups and other programs directed at the bereaved may be needed. Other losses connected with aging (loss of family, loss of friends, loss of status, loss of adequate income, loss of independence) may all require attention.
- The low literacy rate and lack of fluency in English may mean that information distributed by mail is not reaching its target audience.
- People have indicated they were unprepared for old age in many cases. Programs to explain the aging process may have to be targeted toward the preretirement population. At the same time, a realistic picture of old age must be presented.
- Placement due to health problems now often occurs during crises. Pre-education and planning could ease the transition and remove some negative connotations connected with institutionalization.
- If facilities were available in most communities and were integrated into those communities, it is likely that seniors would be more willing to be institutionalized.
- Visiting programs would be both popular and positive. Such programs would involve going visiting themselves and receiving visitors; 'adopt-a-grandparent' programs would be part of such activities; a seniors' 'buddy system' could be explored. These programs could also double as monitoring systems.
- Seniors would like to be involved in planning services which affect them and would also like to lend themselves as volunteers.
- Some concern must be expressed regarding the over-reliance on physicians, some of whom do not have special geriatric training. The elderly must, at this time, receive the physician's approval before other health services can be accessed. This system tends to hinder independence and promote the view of the physician as the ultimate source of information and help.
- As the population ages even more, doctors will find that their patient load will become top-heavy with seniors from this age group. Doctors should be prepared for this and become informed about the various services available to seniors.
- Physicians, and other health care delivery systems, (clinics, for example) are excellent vehicles for information distribution and transmittal. Workshops

for seniors could be attached to clinics as an extension service to help educate and inform.

- Seniors undergo stress when they are referred to specialists in cities. Not only does the strange clinic, hospital or professional frighten them but so does the journey and the urban setting itself.
- Basic services do not exist in most remote communities. As well, since seniors who live in these communities reject the idea of institutionalization, it is possible that some alternative solution must be discovered, perhaps one where family's role is recognized.
- Since people wish to move into institutions only when they can no longer cope on the outside, it is clear that residents of such places are probably going to be older than anticipated, and in greater need of supervision.
- To assist seniors to remain independent and at home as long as possible, home adaptations such as--griprails in bathtubs, reaching aids in kitchens, etc. may be necessary. It may be cheaper, as well, to subsidize domestic services than to provide institutionalization.
- Adult day-care is still another program that has implications for senior independence.
- Seniors know what kind of transportation services would help them and would like to be involved in planning in this regard.
- User-pay programs might need reviewing in light of the fact that 77% of respondents indicate a willingness to pay for domestic services.

- While there is no indication that seniors plan to leave the North in large numbers to seek warmer climates, there is a perceived shift of this population from rural to urban centres. This is evidently so they may be nearer medical and recreational facilities. Perhaps centralization of all types of facilities, is the way of the future.
- Arthritis, blood pressure, memory (or loss of it), hearing and vision are all topics seniors would like to explore.
- Some misunderstanding exists about the differences in services offered and the specific nature of available programs and services.
- Seniors may regard Home Care as a program which helps them remain independent. The foundation of independence begins much earlier through preventative programs such as lifestyle and health education and specialty clinics.

RECOMMENDATIONS

1. The Geriatric Committee recommends that local deliverers of programs for seniors meet at least once a year and share programming information on a formal basis and that, informally, ties and networking be established which would facilitate communication.

2. a) The Geriatric Committee recommends that a new planning and co-ordination model be developed with the focus on information to seniors, co-ordination of services, and involvement of seniors.
   b) The Geriatric Committee further recommends that seniors be highly involved in the evolution of this model and/or any programming which affects them. Planning committees which deal with programming for seniors should be composed of a majority of seniors.

3. a) The Geriatric Committee recommends that information be distributed for all services through health care outlets and that information be made readily available to these facilities.
   b) The Geriatric Committee also recommends that when material is prepared for seniors, it be prepared at appropriate levels of literacy and with clarity.

4. The Geriatric Committee recommends that the distribution of information and the delivery of services be tied to the socialization patterns of seniors whenever possible.

5. The Geriatric Committee recommends that the needs of seniors be reviewed every 10 years and that local concerns be identified and addressed at those time periods.

6. The Geriatric Committee recommends that programming be flexible to meet local needs and that local input be considered in the planning.

7. The Geriatric Committee recommends that new funding approaches be explored with extensive consultation of seniors.

8. The Geriatric Committee recommends that communities recognize that seniors have a positive role to play in all aspects of community life and that seniors should be sought out for their expertise.

9. The Geriatric Committee recommends that community groups be encouraged to consider seeking out and using seniors as volunteers.

10. The Geriatric Committee recommends that in planning for transportation modes and systems for seniors; that flexibility, medical, social and recreational needs be considered, and that seniors' input be sought in this regard.

11. The Geriatric Committee recommends that the role and operation of senior citizen centres be redefined to meet the broader needs of the community and that they become focal points for programming and information dissemination.

12. The Geriatric Committee recommends that the dedication and commitment of families be encouraged and enhanced through education of the population in regard to the aging process. The Geriatric Committee recommends that service providers assist families in their supportive role through the provision of relief services when appropriate.

13. The Geriatric Committee recommends that health care providers consider using regional specialist when appropriate, and that a program be explored which would assist seniors in their travel and accommodation needs to access specialists.

14. The Geriatric Committee recommends that the Alberta Government recognize, through policy and budget allotments, the changing housing needs and the role of lodges, nursing homes and auxiliary hospitals.

15. The Geriatric Committee recommends that Alberta Hospitals and Medical Care consider the distance factor in their future construction projects.

16. The Geriatric Committee recommends that there be greater awareness of the aging process from the physical, psychological and sociological perspectives. The Committee recommends a holistic approach be taken by society.

17. The Geriatric Committee recommends that holistic preretirement education be available to individuals at earlier stages of life.

18. The Geriatric Committee recommends the support of community domestic services, Home Care and Community Health Care Services to assist seniors in their efforts to remain independent.

19. The Geriatric Committee recommends that the wishes and choices of seniors be respected and accepted by agency personnel, and by family.

20. The Geriatric Committee recommends that seniors be given special assistance in completing documentation.

21. The Geriatric Committee recommends that a special committee be established to address the needs of seniors in the remote areas and to specifically focus on programs which meet their needs.

THE NEXT STEP

The work of the Geriatric Committee will not be allowed to gather dust on a shelf. The Committee has agreed to the Peace River Health Unit taking the Report to the community through a series of workshops to explore the possibilities of a new planning model incorporating the findings of the Committee.

VOLUNTEER INTERVIEWERS WHO ASSISTED IN ~~THIS~~ PROJECT

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June Skip, Peace River
Mrs. Simpson, Peace River
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Avis May, Manning
Pat Mabley, Manning
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Lorna Kemp, High Prairie
Gwen Carson, High Prairie
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SUB-COMMITTEE OF THE INTERDISCIPLINARY COMMITTEE FOR GERIATRIC SERVICES IN THE NORTH PEACE REGION (THE GERIATRIC COMMITTEE)

Molly Hopcraft (Chair) Supervisor of Community Health Nursing,
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George Kupfer (Research Adviser) President,
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Sue Long, (Project Co-ordinator), Peace River
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Cobus Vreeling, Chair, Manning Hospital Board
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Margie Gravel, Supervisor of Home Care Program, Peace River Health Unit
Muriel Oslie, Member of Advisory Council to Senior Citizens Bureau,
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Isaac Graham, Chair, Ministerial Association, Fairview
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